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GOLDEN LIVINGCENTER-ALLEGHANY	1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/21/2015 through 1/22/2015. Three complaints were investigated. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 105 certified bed facility was 103 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents # 1 through 18, 22 and 23) and four closed record reviews (Residents # 19 through 21 and 24).	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of our agreement with the facts and conclusions set forth on the survey report. our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 155 SS=G	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 2/3/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosabte 90 days following the date of survey whether or not a ptan of correction is provided. For nursing homes, the above findings and plans of correction are disclosabte 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved ptan of correction is requisite to continued program participation.

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This REQUIREMENT is not met as evidenced by:
Based on review of a Facility Reported Incident, clinical record review, facility document review, and staff interview, the facility staff failed, for one of 24 residents in the survey sample (Resident # 20), to honor the resident's Advance Directives decision. The resident, who had a resuscitation order, was pronounced dead without the initiation of cardiopulmonary resuscitation (CPR).

The findings were:

Resident # 20 in the survey sample, an 88 year-old male, was admitted to the facility on 6/10/11 with diagnoses that included hypertension, cerebral atherosclerosis, history of femoral neck fracture, Alzheimer's Disease, anxiety state, hyperlipidemia, peripheral vascular disease, and osteoporosis. According to a Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/14, and Medicare 60-Day MDS with an ARD of 11/10/14, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

Review of the Progress (Nurses) Notes in the resident's closed clinical record revealed the following entries:

11/21/14 - 3:04 a.m. "Resident at 0248 observed by staff during an adl (Activities of Daily Living) round with no signs of life. Notified RN (Registered Nurse) on duty in facility. RN assessed resident. RN observed no vital signs.

Past noncompliance: no plan of correction required.

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RN also notified MD and nursing supervisor and family. Family gave facility funeral home preference and the funeral (home) was contacted by RN."

11/21/14 - 3:11 a.m. "At approx (approximately) 0245 c-wing nurse notified this writer of possible death this nurse assessed resident for signs of life resident presented with no respirations or pulse this writer pronounced death at 0248 this writer notified nursing supervisor, M.D., and next of kin family gave funeral home preference funeral home notified.(sic)"

According to the Death Certificate, the immediate cause of death for Resident # 20 was myocardial infarction.

On 11/24/2014, the facility submitted a Facility Reported Incident (VA00030682) that noted the following, "Resident pronounced dead at 2:48 am by the RN charge nurse. Resident noted during the Director of Nursing's follow-up chart review to have a current order for full code."

Resident # 20's clinical record included a "Resuscitation Orders" form, dated 6/13/11 and signed by the attending physician, that noted the following:

"The resident or the resident's decision maker is aware of the medical condition of the resident. After fully discussing and considering the risks/benefits and alternatives to the initiation of CPR in a cardiac or respiratory arrest, the resident or the resident's representative had made the following decision: In the event of a cardiac and/or respiratory arrest, initiate CPR."

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At 11:30 a.m. on 1/22/15, during a meeting the administrative staff, which included the Administrator and the Director of Nursing, the survey team addressed their concerns over the lack of CPR for Resident # 20. The administrative staff offered no new information prior to the survey Exit Conference.

The facility submitted the following information concerning their plan of correction.

QAPI committee reviewed the self report initiated 11/21/14 and subsequent follow-up plan and is agreeable with action taken and monitoring that will occur. Compliance date for completion will be 11/26/14....

As follow-up to this event the facility has taken the following action steps:

* Licensed nurses have been re-educated to the process for checking and implementing advance directives including the "code" process and use of the AED

* The current CPR certification status of all Licensed nurses has been reviewed with immediate courses offered by the contracted vendor for those in need of refreshment. It was confirmed that CPR certified staff were present at the time of the investigated event.

* The Executive Director re-educated the Director of Clinical Education and the Office Manager on the process for ensuring proper tracking of CPR certification in the Peoplesoft system.

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*In-house expirations for the prior 6 months were reviewed for reporting to QAPI assurance that protocols were followed.

* All open charts were audited by Medical Records and Social Services to ensure that codes status were correctly documented.

* All open charts were audited to ensure that documents were filed within the correct file jackets.

* Mock Code Drills initiated on all shifts

* Hospice administration verified the accuracy of their code status

* Crashcarts were re-assessed to ensure all necessary supplies were accessible.

* The Care plan team reviewed current code status for each active Resident with Resident/RP to ensure that current wishes are being honored.

A new process was initiated on 11/24/14 in which a label with the Resident's name clearly printed in Red Ink was placed at the top of each DNR form to ensure easy validation if the form were to become misfiled or the signature be illegible. Staff with access to Medical Records, including hospice nurses were in-serviced on this new process along with re-education on the critical aspect of double checking that documents are being filed into the correct resident jacket.

Monitoring of compliance will occur as follows:

The Executive Director will run the list of Residents that expired in-house from Point Click

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F 155	Continued From page 5 Care during the completion of the monthly operations report. This list will be compared to the physicians' orders to ensure that code statuses were implemented properly. The ED will report findings to both the Area VP and QAPI via the OPS report for additional follow-up. The Executive Director/designee will run a list of new DNR orders during the completion of the monthly operations report. The charts affected will be checked to ensure that the documents for that Resident are in the Resident's jacket and have been labeled as per the new process. The ED will report findings to both the Area VP and QAPI via the OPS report for additional follow-up. Nursing Administration will continue their end of month chart audits with greater focus on ensuring that documents are housed in the correct Resident's file jacket. Any identified concerns will be corrected immediately and reported to the DNS for trending and follow-up to the QAPI committee.	F 155		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this	F 164		

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section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on medication pass and pour observation and staff interview, the facility staff failed to maintain confidential electronic medical record (s) on one of 3 units: B wing. Staff left confidential resident information displayed on the computer screen.

Findings include:

A medication pass and pour observation was conducted 1/21/15 beginning at 7:45 a.m. with LPN (licensed practical nurse) # 2 . As this surveyor approached LPN # 2 , she stated "I'll be right back. I need to go to (name of resident)'s room." This surveyor noted the computer screen on the medication cart was left up displaying a resident's picture including personal information (i.e. name, date of admission, medical diagnoses, etc.). Approximately two to three minutes passed; the computer screen did not go to a

LPN #2 was re-educated on 1/21/15 as to the need to close/lock out the computer screen when leaving the computer unattended to prevent exposure of personal information.

All Residents have the potential to be affected by this potential deficient practice.

Current licensed nurses to be re-educated on or before 2/6/15 by the Director of Clinical Education/designee as to the need to close/lock out the computer screen when leaving the computer unattended to prevent exposure of personal information. A requirement to check to observe this practice has been added to the Department Manager's non-clinical rounds sheets for observation on daily rounds, with immediate corrective action as needed. Non-clinical rounds sheets will be turned in to the Director of Nursing for additional education as required.

The Director of Nursing will trend issues noted on the Non-clinical rounds sheets and provide this trending to QAPI monthly for 3 months to ensure compliance has heen achieved or for additional recommendations if required.

Date of compliance: 2/11/15

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F 164	Continued From page 7 screensaver mode. During this time, several staff were walking up and down the hallway. The medication cart was parked just outside a resident room, and a resident was standing beside the cart. As this surveyor and LPN # 2 continued the med pass, LPN # 2 left the computer screen up with resident information displayed and left unattended when administering medications in a resident room. The administrator and DON (director of nursing) were informed of the above observations during a meeting with facility staff 1/21/15 beginning at 2:15 p.m. On 1/21/15 at approximately 3:55 p.m. LPN # 2 was interviewed regarding the computer screen being left up with resident information displayed. LPN # 2 stated "Usually, the computer will go into screensaver mode after a few seconds of inactivity; I don't know what happened. I've been shutting the lid of the computer the rest of the day so the information won't be displayed." No further information was provided prior to the exit conference.	F 164		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224	F224 Resident #14 was immediately assessed by nursing and a treatment obtained for her burn. The PT involved in the incident was removed from practice at this facility and investigated with notifications to APS/Ombudsman/VDH and DHP. The incident was reviewed with facility direct care staff in daily huddles the following morning for assistance with future prevention and awareness of risks.	

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This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, family interview, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to ensure one of 24 residents was free from negligence during treatment with a therapy device. A physical therapist left Resident #14 unattended during electrical stimulation (e-stim) therapy which was against the facility's clinical practice guidelines for use of the device. During the unsupervised treatment the resident experienced four (4) second degree burns to her left thigh that required over three months of topical treatment in addition to 7 days of oral antibiotic therapy for infection in the wounds. The resident had scarring to her thigh from the burns.

The findings include:

Resident #14 was admitted to the facility on 3/30/10 with diagnoses that included intellectual disability, depressive disorder, psychosis, dementia, hypothyroidism, hyperlipidemia, seizure disorder, gastroesophageal reflux disease and obstructive sleep apnea. The minimum data set (MDS) dated 1/9/15 assessed Resident #14 as cognitively intact. This MDS assessed Resident #14 had limited range of motion of both lower extremities and required the extensive assistance of two people for bed mobility.

A facility reported incident form dated 1/2/14 documented Resident #14 experienced four second degree burns to her left thigh as a result of unsupervised treatment with an electrical

The GEM Program Specialist with Aegis Therapies, came in the facility on 1/2/14 and reviewed the incident and equipment. No additional concerns were noted. On 1/3/14 the Area Vice President of Aegis Therapies notified the Executive Director that the Aegis National Director of Senior Research would be contacting Chattanooga and the FDA to report the incident and insure that all proper channels were followed to protect all residents. No other situations of this type are known to have occurred in this facility.

Facility staff to be re-educated by the Director of Clinical Educations/ designee on or before 2/6/15 as to the requirement to ensure that E-stim treatments are provided under direct supervision. The GEM program Specialist will re-educate the therapy staff on the policies regarding supervision during E-stim treatments on or before 2/6/15. The E-Stim equipment continues to be inspected by Patterson Medical for calibration and safety annually as required. The Aegis GEM Program Specialist will continue to visit at least quarterly and assesses compliance with safety practices in regards to the E-Stim equipment with immediate corrective action and education provided as needed. A report of his findings will be provided to the facility Executive Director.

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stimulation device on 12/31/13. The report documented: "On 12/31/13 (Resident #14) received e-stim treatment to her left thigh for management of pain. This treatment was administered by (physical therapist). The treatment was documented as being a 25 minute procedure. Upon completion of the treatment, four (4) burns were noted to the left thigh in the locations where two (2) electrodes had been placed. The investigation shows that the Physical Therapist administering the treatment had violated policy regarding maintaining line of sight/direct supervision of the Resident during the duration of an e-stim treatment. It is determined that this event meets the definition of neglect and as a result this contractor has been removed from practice at this facility..."

On 1/21/15 at 4:00 p.m. Resident #14 was observed in bed. The resident's family member was in the room with the resident. The resident's family member who was with Resident #14 on 12/31/13 was interviewed at this time about the burns to the resident's thigh. The family member stated she witnessed the physical therapist apply the stimulation device electrode pads to the resident's left thigh area. The family member stated, "(Resident #14) told her (physical therapist) it was hurting, that it was too much." The family member stated the therapist told Resident #14 that she could not turn the setting down any further or the device would be off. The family member stated the therapist then accompanied her out of the room to walk with her walker to the C wing. The family member stated when they were coming back from C wing, "I heard her (Resident #14) hollering." The family member stated when she and the therapist got back to the room the therapist did not

The Executive Director will review the Aegis GEM Program Specialists reports for trends and submit this information at least quarterly to the QAPI Committee for additional recommendations and to ensure compliance with this plan.

Compliance date: 2/11/15

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immediately remove the e-stim pads even though Resident #14 was yelling in pain. The family member stated the therapist told Resident #14 she still had a few more minutes for the device to be applied. The family member stated when the therapist removed the e-stim electrodes from the resident's thigh the resident's skin under the electrode pads was burned. The family member stated, "It (burns) hurt her terrible. It took months for the burns to heal." The family member stated, "I don't think she (therapist) took her (Resident #14) serious when she said it (e-stim therapy) hurt." The family member stated the burns healed but left scars on the resident's thigh. The family member at this time pulled back the resident's bed sheet and made visible the resident's left thigh area. The resident had an irregular shaped, linear, dark pink/purplish slightly raised scar on her left outer thigh. Below this was a small, slightly oval dime size dark pink/purplish raised scar. The family member stated these were the scars from the burns from the unsupervised e-stim therapy of 12/31/13.

On 1/22/15 at 7:50 a.m. Resident #14 was interviewed about the burns to her left thigh from the e-stim device. Resident #14 stated, "It (e-stim) hurt when she (therapist) put it on. I told her (therapist) and she left it and went away. It hurt the whole time it was on." Resident #14 stated the therapist left her after applying the device and when she returned and took the electrodes off, the skin was burned. Resident #14 stated the burns left scars on her leg and took a long time to heal. Resident #14 stated she did not know why the therapist left the electrodes in place after she expressed pain/discomfort.

Resident #14's clinical record was reviewed on

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1/22/15. The resident had a physician's order dated 11/26/13 for physical therapy (5 times per week for 12 weeks) that included e-stim therapy to the left thigh area for pain management. Resident #14's therapy log for December 2013 documented the resident received 16 e-stim treatments prior to 12/31/13. The entry on the therapy log listed the treatment to be supervised. The log stated, "Electrical stimulation, (Supervised), to one or more areas..." The treatments in December 2013 were documented as lasting from 15 to 30 minutes each. The treatment on 12/31/13 was listed as a 20 minute session.

The clinical record including nursing notes, physician progress notes and physician orders documented ongoing topical treatment and dressing changes to the burns from 12/13/13 through 4/22/14. In addition to topical treatments the resident was prescribed/administered seven days of antibiotic therapy due to infection in the wounds. Nursing notes documented the following progress of Resident #14's burns.

12/31/13 at 2:11 p.m. - "Resident sustained burn wound to L (left) thigh...There is a grouping of three burn wounds to proximal L thigh and a single burn to distal L thigh. Measurements of three burn wounds in proximal group are... 1.2 cm (centimeters) x 0.5 cm... 2.8 cm x 1 cm and... 1.2 cm x 0.9 cm. Distal burn wound measures 1.5 cm x 0.7 cm. Wound beds are pale light green in color with white defined margins..."
1/13/14 - "Negative healing to L thigh burn wound with new order noted for tx (treatment)...Upper grouping of wounds with soft yellow slough tissue and heavy thin yellow drainage with no odor. Surrounding tissue reddened with warmth

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noted..."
1/14/14 - "Resident was examined by MD (physician) this morning, resident received new orders regarding wound infection. Keflex 500 mg (milligrams) QID (four times per day) for seven days...new treatment orders are to: Gently scrub burn wound to L distal thigh with soap/water using sponge of toothette, rinse with water and pat dry. Apply Silvadene cream 1% and cover with Tegaderm silicone foam dressing BID (twice per day)..."
1/15/14 - "Resident con't (continues) on abx (antibiotic) for wound infection..."
1/16/14 - "Continues on ABT therapy for wound infection..."
1/18/14 - "Keflex continues per order for wound infection, left thigh..."
1/19/14 - "Continues on ABT therapy Keflex for wound infection..."
1/20/14 - "Continues on ABT therapy Keflex for wound infection...Dressing changed to left thigh as ordered..."
2/20/14 - Positive healing noted to burn wounds L proximal thigh and L distal thigh...Areas are red granulated tissue with red rimmed circular margins..."
3/6/14 - "Resident with positive healing to L proximal thigh wound and L distal thigh wound..."
3/28/14 - "resident continues with burns to left thigh with tx (treatment) in place no other skin issues noted..."
4/4/14 - "resident continues with burns to left thigh..."
4/15/14 - "...Treatments continue to burn areas per order..."

A physician progress note dated 1/3/14 documented, "Pt (patient) suffered 4 superficial burns to L thigh by use of stimulation in PT

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(physical therapy)...L thigh (with) 4 small partial thickness burns..." A progress note dated 1/14/13 stated, "3 ulcers high L outer thigh 1 mid thigh all are about 2 cm in diameter...surrounding erythema on the upper ones..."

The clinical record documented the following sequence of physician orders for treatment of the resident's burns on her left thigh.

12/31/13 - "Cleanse grouping of three burn wounds to proximal L thigh with NSS (normal saline solution) and pat dry. Cleanse burn wound to distal L thigh with NSS and pat dry. Apply Hydrogel to all wounds and cover with Medipore + pad dressing QD (each day) every day shift."
1/13/14 - "Cleanse grouping of three burn wounds to proximal L thigh with NSS and pat dry. Cleanse burn wound to distal L thigh with NSS and pat dry. Apply santyl oint (ointment) to wound beds. Cover each area with Tegaderm silocone (silicone) foam dressing QD (each day)..." (sic)
1/14/14 - "Keflex 500 mg (milligrams) QID (four times per day) for 7 days"
1/14/14 - Gently scrub burn wound to L distal thigh with soap/water using sponge of toothette, rinse with water and pat dry. Apply Silvadene cream 1% and cover with Tegaderm silicone foam dressing BID (twice per day) every day and night shift."
2/20/14 - "Cleanse L proximal thigh with wound cleanser and pat dry. Apply Silvadene cream and cover with Medipore + pad BID (twice per day)...Cleans L distal thigh with wound cleanser and pat dry. Apply Silvadene cream and cover with Medipore + pad BID..."
3/6/14 - "Cleanse L distal thigh with wound cleanser and pat dry. LOTA (leave open to air)

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BID...Cleanse L proximal thigh with wound cleanser and pat dry. LOTA (leave open to air) BID..."

Treatment and dressing changes to Resident #14's thigh burns were discontinued on 4/22/14.

Resident #14's MDS prior to the incident (dated 11/8/13) assessed Resident #14 to require the extensive assistance of two people for bed mobility and transfers. This MDS listed the resident did not ambulate and had limited range of motion of both lower extremities. The resident's care plan during December 2013 listed the resident was at risk for altered skin integrity due to decreased mobility, obesity and left sided weakness. The care plan documented the resident had "Physical functioning deficit related: MR (mental retardation)/decreased mobility with bilateral weakness..." The care plan listed the resident required two aides at all times for mobility and provision of direct care.

On 1/22/15 at 9:00 a.m. the director of rehab services was interviewed about Resident #14's burns following e-stim treatment on 12/31/13. The rehab director described the e-stim equipment as a device designed to provide electrical stimulation for the treatment of chronic pain. The rehab director demonstrated the portable device had electrodes connected to lead wires. The rehab director stated the positioning of the electrode pads and settings for the treatment were determined and adjusted by the therapist providing the treatment. The rehab director stated Resident #14 received several weeks of treatment with the e-stim device prior to the incident on 12/31/13. The rehab director stated the e-stim machine used with Resident

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#14 on 12/31/13 was inspected and found to be free of malfunction. The rehab director stated the device had annual calibration performed as required with no calibration issues noted. The rehab director stated the facility's protocol for use of the device required supervision of the resident during treatment.

On 1/22/15 at 9:05 a.m. the administrator was interviewed about Resident #14's burns from e-stim therapy. The administrator stated her investigation of the 12/31/13 incident revealed the physical therapist started the e-stim therapy to Resident #14's thigh area and then walked with the resident's family member from B wing to C wing and back. The administrator stated as the family member and therapist were coming back from C wing, they heard Resident #14 yelling. The administrator stated when the e-stim pads were removed the resident had 4 burns to the thigh area where the pads had been placed. The administrator stated the physical therapist involved had prior training on use of the e-stim equipment. The administrator stated the policy for use of the device clearly stated the resident must never be left unsupervised or out of direct line of sight during treatment. The administrator stated their investigation concluded the incident met the definition of neglect because the resident had poor mobility and the facility's documented guidelines for the safe use of the device required continuous supervision and assessment during the treatment.

The facility's policy titled, Electrical Stimulation Clinical Practice Guideline (revision date 11/16/09) documented, "Treatment with electrical stimulation involves the introduction of an electric current from an external source to a muscle or

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nerve. The flow of ions (positive or negative) causes an opposite disruption of the membrane potential which can result in 1) nerve impulses that cause a contraction of muscle, 2) activation of nerve impulses to block transmission of other nerve impulses (as in pain management), and 3) increase circulation which stimulates cellular activity to promote tissue healing and reduce inflammation." This policy listed procedures for use of this device to include, "Prior to first treatment...Make it clear that any stinging, pain or burning sensation under the electrodes is NOT a normal response and that ANY discomfort during treatment must be reported immediately...Establish a clear, reliable method that the patient will use to communicate/signal any treatment intolerance or discomfort..All electrical stimulation treatments MUST be provided in either supervised/line of sight or direct supervised settings. The patient is NEVER to be left unattended or unsupervised...Frequently monitor the skin response during all treatments to confirm acceptable levels...Adjust the treatment setting on the unit in order to achieve the desired response. Verify comfort and tolerance of the patient...Remind the patient to notify treating therapist of any discomfort during the treatment..."

The Lippincott Manual of Nursing Practice 10th Edition on page 1184 defines a second degree burn as a burn assessed with loss of partial skin thickness. This reference describes the characteristics of a superficial second degree burn as, "Pink or red; blisters (vesicles) form; weeping, edematous, and elastic...Superficial layers of skin are destroyed; wound moist and painful...Takes several weeks to heal...Scarring may occur..." (1)

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These findings were reviewed with the administrator and director of nursing on 1/22/15 at 11:45 a.m.

This was a complaint deficiency.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

F 279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS — F 279

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record

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review, the facility staff failed to develop a comprehensive care plan for one of 24 residents in the survey sample. Resident #7, administered nightly doses of the hypnotic medication Ambien, had no care plan developed for insomnia.

The findings include:

Resident #7 was admitted to the facility on 1/7/13 with diagnoses that included below knee amputation, chronic obstructive pulmonary disease, insomnia, depressive disorder, traumatic brain injury, anxiety, coronary artery disease, congestive heart failure, diabetes, anemia, hypertension, episodic mood disorder and psychosis. The minimum data set (MDS) dated 11/14/14 assessed Resident #7 as cognitively intact and having trouble falling or staying asleep 7 to 11 out of 14 days.

Resident #7's clinical record was reviewed on 1/21/15. The record documented a physician's order dated 9/4/14 for the hypnotic medication Ambien (zolpidem tartrate) 5 mg (milligrams) to be administered as needed for insomnia at bedtime. The resident's medication administration record (MAR) for January 2015 (through 1/20/15) documented the resident was administered Ambien at bedtime on 18 out of 20 days in January 2015.

The resident's care plan (print date 1/21/15) listed the resident was prescribed and administered a hypnotic but included no problems, goals and/or interventions to address the resident's insomnia.

On 1/21/15 at 1:05 p.m. the registered nurse MDS coordinator (RN #1) responsible for care plans was interviewed about a plan of care for

A care plan with specific goals and interventions for insomnia was developed on 1/22/15 for Resident #7.

Current Residents with prescribed hypnotic medication were reviewed on 1/3/15 to ensure that care plans with specific goals and interventions for insomnia were in place with corrective measures taken as needed.

The Interdisciplinary team (IDT) to be re-educated by the Director of Clinical Education/designee on or before 2/6/15 as to the requirement for all residents receiving a hypnotic to have a care plan specific to insomnia. The order by order report will be printed daily and brought to the clinical start-up meeting to ensure that all new orders for hypnotics are communicated to the IDT for care planning purposes. The Director of Nursing will request validation at the end of day meeting that the care plan has in fact been implemented.

The Social Worker will run a report of all hypnotics monthly and audit to ensure that care plans are current related to insomnia. Her findings will be submitted to QAPI monthly for three months to ensure compliance with the plan or for additional recommendations if needed.

Compliance date: 2/11/15

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F 279	Continued From page 19 Resident #7's insomnia. RN #1 stated the care plan listed the resident used a hypnotic but did not provide goals and/or interventions concerning his sleep problems. RN #1 stated, "We didn't list insomnia as a problem. I don't see that. We don't have interventions specifically for insomnia." These findings were reviewed with the administrator and director of nursing during a review meeting on 1/21/15 at 2:00 p.m.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of a Facility Reported Incident, clinical record review, facility document review, and staff interview, the facility staff failed, for one of 24 residents in the survey sample (Resident # 20), to honor the resident's Advance Directives decision to initiate cardiopulmonary resuscitation (CPR) in the event of a cardiac and/or respiratory arrest. A Licensed Practical Nurse, who responded to the resident's cardiac event, failed to verify that the name on a Do Not Resuscitate order found in Resident # 20's clinical record was that of the resident. The findings were: Resident # 20 in the survey sample, an 88 year-old male, was admitted to the facility on 6/10/11 with diagnoses that included hypertension, cerebral atherosclerosis, history of	F 281	Past noncompliance: no plan of correction required.	

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femoral neck fracture, Alzheimer's Disease, anxiety state, hyperlipidemia, peripheral vascular disease, and osteoporosis. According to a Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/14, and Medicare 60-Day MDS with an ARD of 11/10/14, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

Review of the Progress (Nurses) Notes in the resident's closed clinical record revealed the following entries:

11/21/14 - 3:04 a.m. "Resident at 0248 observed by staff during an adl (Activities of Daily Living) round with no signs of life. Notified RN (Registered Nurse) on duty in facility. RN assessed resident. RN observed no vital signs. RN also notified MD and nursing supervisor and family. Family gave facility funeral home preference and the funeral (home) was contacted by RN."

11/21/14 - 3:11 a.m. "At approx (approximately) 0245 c-wing nurse notified this writer of possible death this nurse assessed resident for signs of life resident presented with no respirations or pulse this writer pronounced death at 0248 this writer notified nursing supervisor, M.D., and next of kin family gave funeral home preference funeral home notified.(sic)"

According to the Death Certificate, the immediate cause of death for Resident # 20 was myocardial infarction.

Resident # 20's clinical record included a

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"Resuscitation Orders" form, dated 6/13/11 and signed by the attending physician, that noted the following:

"The resident or the resident's decision maker is aware of the medical condition of the resident. After fully discussing and considering the risks/benefits and alternatives to the initiation of CPR in a cardiac or respiratory arrest, the resident or the resident's representative had made the following decision: In the event of a cardiac and/or respiratory arrest, initiate CPR."

On 11/24/2014, the facility submitted a Facility Reported Incident (VA00030682) that noted the following, "Resident pronounced dead at 2:48 am by the RN charge nurse. Resident noted during the Director of Nursing's follow-up chart review to have a current order for full code."

The facility's investigation report of the event noted the following. "LPN (name) checked (name of Resident # 20) chart and found a yellow DNR (Do Not Resuscitate) form and determined (name of Resident # 20) to be a DNR." Based on the finding of the DNR form by the LPN (identified by the survey team as LPN # 7), resuscitation efforts were not initiated and the Resident # 20 was pronounced as deceased.

The investigation report further noted that it was "...later discovered during chart review that the yellow DNR form in (name of Resident # 20) was not his, but belonged to another resident (Resident # 24)."

On 1/22/15 at 1:30 p.m., during an overview of the facility's Quality Assurance Program, the Administrator said that LPN # 7 looked at

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Resident # 20's chart, saw the DNR form and incorrectly assumed it was for Resident # 20. According to the Administrator, the signatures of Residents # 20 and 24 looked to be similar, so when LPN # 7 looked at the signature, she thought the DNR form was for Resident # 20. The Administrator went on to say that it was during the chart review conducted by the Director of Nursing after the resident's death that it was discovered the DNR form for Resident # 24 was incorrectly filed in Resident # 20's clinical record.

The facility submitted the following information concerning their plan of correction.

QAPI committee reviewed the self report initiated 11/21/14 and subsequent follow-up plan and is agreeable with action taken and monitoring that will occur. Compliance date for completion will be 11/26/14....

As follow-up to this event the facility has taken the following action steps:

* Licensed nurses have been re-educated to the process for checking and implementing advance directives including the "code" process and use of the AED

* The current CPR certification status of all Licensed nurses has been reviewed with immediate courses offered by the contracted vendor for those in need of refreshment. It was confirmed that CPR certified staff were present at the time of the investigated event.

* The Executive Director re-educated the Director of Clinical Education and the Office

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Manager on the process for ensuring proper tracking of CPR certification in the Peoplesoft system.

*In-house expirations for the prior 6 months were reviewed for reporting to QAPI assurance that protocols were followed.

* All open charts were audited by Medical Records and Social Services to ensure that codes status were correctly documented.

* All open charts were audited to ensure that documents were filed within the correct file jackets.

* Mock Code Drills initiated on all shifts

* Hospice administration verified the accuracy of their code status

* Crashcarts were re-assessed to ensure all necessary supplies were accessible.

* The Care plan team reviewed current code status for each active Resident with Resident/RP to ensure that current wishes are being honored.

A new process was initiated on 11/24/14 in which a label with the Resident's name clearly printed in Red Ink was placed at the top of each DNR form to ensure easy validation if the form were to become misfiled or the signature be illegible. Staff with access to Medical Records, including hospice nurses were in-serviced on this new process along with re-education on the critical aspect of double checking that documents are being filed into the correct resident jacket.

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F 281	Continued From page 24 Monitoring of compliance will occur as follows: The Executive Director will run the list of Residents that expired in-house from Point Click Care during the completion of the monthly operations report. This list will be compared to the physicians' orders to ensure that code statuses were implemented properly. The ED will report findings to both the Area VP and QAPI via the OPS report for additional follow-up. The Executive Director/designee will run a list of new DNR orders during the completion of the monthly operations report. The charts affected will be checked to ensure that the documents for that Resident are in the Resident's jacket and have been labeled as per the new process. The ED will report findings to both the Area VP and QAPI via the OPS report for additional follow-up. Nursing Administration will continue their end of month chart audits with greater focus on ensuring that documents are housed in the correct Resident's file jacket. Any identified concerns will be corrected immediately and reported to the DNS for trending and follow-up to the QAPI committee.	F 281	F 281	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F 309 Resident #20 was deceased prior to the survey. The physician for Resident #7 reviewed the prn use of oxycodone on 1/22/15 and scheduled the medication. The physician for Resident #12 was notified of the blood sugars greater than 400, and missed medications and weights on 1/22/15.	

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F 309	Continued From page 25	F 309	All open charts were audited to ensure that appropriate advance directive documents were in place by medical records and social services on 11/26/14. All Residents with PRN pain medication and sliding scale insulin are at risk of this potential deficient practice. Weight orders to be audited on or before 2/3/15 for compliance with immediate corrective action if any concerns identified. A new process was initiated on 11/24/14 in which a label with the Resident's name clearly printed in Red ink was placed at the top of each DNR form to ensure easy validation if the form were to become misfiled or the signature be illegible. Staff with access to Medical Records, including hospice nurses were in-serviced on this new process along with re-education on the critical aspect of double checking that documents are being filed into the correct resident jacket. Staff were trained on this new process prior to the survey. All Residents receiving PRN pain medication had the supplemental documentation icon turned on within the electronic medication administration system on 1/31/15 to prevent administration of the medication without a documented pain assessment. Restorative Aides will now attend the weekly clinical meeting to ensure they have communication as to discussed order changes for weights. Weight orders will be printed and verified during this meeting.	

This REQUIREMENT is not met as evidenced by:
Based on review of a Facility Reported Incident, clinical record review, staff interview, and review of facility documents, the facility staff failed, for three of 24 residents in the survey sample (Residents # 7, 12 and 20), to follow physician's orders for cardiopulmonary resuscitation, pain medication administration, blood sugar monitoring, weight monitoring, and medication administration.

1. The facility staff failed to provide Resident # 20 with physician ordered cardiopulmonary resuscitation when the resident suffered a cardiac event.

2. Facility staff failed to follow a physician's order to assess Resident #7's pain using a numeric scale prior to administering the pain medication oxycodone.

3. Facility staff failed to follow physician orders for reporting blood sugars greater than 400, obtaining weights and administering medications to Resident #12.

The findings include:

1. The facility staff failed to provide Resident # 20 with physician ordered cardiopulmonary resuscitation when the resident suffered a cardiac event.

Resident # 20 in the survey sample, an 88 year-old male, was admitted to the facility on 6/10/11 with diagnoses that included

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hypertension, cerebral atherosclerosis, history of femoral neck fracture, Alzheimer's Disease, anxiety state, hyperlipidemia, peripheral vascular disease, and osteoporosis. According to a Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/14, and Medicare 60-Day MDS with an ARD of 11/10/14, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

Review of the Progress (Nurses) Notes in the resident's closed clinical record revealed the following entries:

11/21/14 - 3:04 a.m. "Resident at 0248 observed by staff during an adl (Activities of Daily Living) round with no signs of life. Notified RN (Registered Nurse) on duty in facility. RN assessed resident. RN observed no vital signs. RN also notified MD and nursing supervisor and family. Family gave facility funeral home preference and the funeral (home) was contacted by RN."

11/21/14 - 3:11 a.m. "At approx (approximately) 0245 c-wing nurse notified this writer of possible death this nurse assessed resident for signs of life resident presented with no respirations or pulse this writer pronounced death at 0248 this writer notified nursing supervisor, M.D., and next of kin family gave funeral home preference funeral home notified.(sic)"

According to the Death Certificate, the immediate cause of death for Resident # 20 was myocardial infarction.

The Medical Director modified sliding scale insulin orders to better match each individuals insulin coverage orders, with notifications to only occur for blood sugar readings outside of order coverage limits. Nursing Administration will run nurses notes and the medication administration audit tool daily for review and corrective action during their daily startup meeting. This report will also be reviewed a second time during end of day meeting .
Staff to receive education on all of these on new processes by the Director of Clinical Education/designee on or before 2/6/15.

The Executive Director/designee will run a list of new DNR orders during the completion of the monthly operations report. The charts affected will be checked to ensure that the documents for that Resident are in the Resident's jacket and have been labeled as per the new process. The ED will report findings to both the Area VP and QAPI via the OPS report for additional follow-up.
Nursing Administration will continue their end of month chart audits with greater focus on ensuring that documents are housed in the correct Resident's file jacket.
They will also review weight orders, blood sugar notifications to the MD and Pain Scale completion. Any identified concerns will be corrected immediately and reported to the DNS for trending and follow-up to the QAPI committee.

Completion date: 2/11/15

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Resident # 20's clinical record included a "Resuscitation Orders" form, dated 6/13/11 and signed by the attending physician, that noted the following:

"The resident or the resident's decision maker is aware of the medical condition of the resident. After fully discussing and considering the risks/benefits and alternatives to the initiation of CPR in a cardiac or respiratory arrest, the resident or the resident's representative had made the following decision: In the event of a cardiac and/or respiratory arrest, initiate CPR."

In a recapitulation of Resident # 20's stay, dated 11/24/14, the attending physician noted, "As per family's wishes he has remained a do CPR code status."

On 11/24/2014, the facility submitted a Facility Reported Incident (VA00030682) that noted the following, "Resident pronounced dead at 2:48 am by the RN charge nurse. Resident noted during the Director of Nursing's follow-up chart review to have a current order for full code."

The facility's investigation report of the event noted the following. "LPN (name) checked (name of Resident # 20) chart and found a yellow DNR (Do Not Resuscitate) form and determined (name of Resident # 20) to be a DNR." Based on the finding of the DNR form by the LPN (identified by the survey team as LPN # 7), resuscitation efforts were not initiated and the Resident # 20 was pronounced as deceased.

The investigation report further noted that it was "...later discovered during chart review that the yellow DNR form in (name of Resident # 20) was

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not his, but belonged to another resident (Resident # 24)."

At 1:30 p.m. on 1/22/15, during an overview of the facility's Quality Assurance Program, the Administrator said the LPN # 7 looked at Resident # 20's chart, saw the DNR form and incorrectly assumed it was for Resident # 20. According to the Administrator, the signatures of Residents # 20 and 24 looked to be similar, so when LPN # 7 looked at the signature, she thought the DNR form was for Resident # 20. The Administrator went on to say that it was during the chart review conducted by the Director of Nursing after the resident's death that it was discovered the DNR form for Resident # 24 was incorrectly filed in Resident # 20's clinical record.

2. Facility staff failed to follow a physician's order to assess Resident #7's pain using a numeric scale prior to administering the pain medication oxycodone.

Resident #7 was admitted to the facility on 1/7/13 with diagnoses that included below knee amputation, chronic obstructive pulmonary disease, insomnia, depressive disorder, traumatic brain injury, anxiety, coronary artery disease, congestive heart failure, diabetes, anemia, hypertension, episodic mood disorder and psychosis. The minimum data set (MDS) dated 11/14/14 assessed Resident #7 as cognitively intact

Resident #7's clinical record was reviewed on 1/21/15. The record documented a physician's order dated 9/4/14 stating, "Assess level of pain before medicating resident by using numeric pain scale: 0-10. 0 = No pain; 10 = Worst Pain..."

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The record documented a physician's order for the opioid analgesic oxycodone 10 mg (milligrams) to be administered every 6 hours as needed for pain. The resident's medication administration record (MAR) from 1/1/15 through 1/20/15 was reviewed. The MAR documented the resident was administered a total of 64 doses of oxycodone during this time period. Nursing notes and medication administration notes documented a numeric pain rating for only 17 of the 64 doses of oxycodone administered to Resident #7 from 1/1/5 through 1/20/15 leaving 47 doses of oxycodone administered without a numeric rating.

On 1/21/15 at 12:50 p.m. the licensed practical nurse (LPN #2) that routinely administered medications to Resident #7 was interviewed about rating the resident's pain. LPN #2 stated she did not always get a pain rating from the resident prior to administration of the oxycodone. LPN #2 stated Resident #7 complained of pain frequently and specifically requested the oxycodone. LPN #2 reviewed the medication administration notes and nursing notes. LPN #2 stated the pain rating should have been documented in the nursing notes. LPN #2 stated she did not see a pain rating documented for most of the oxycodone doses administered in January (2015).

These findings were reviewed with the administrator and director of nursing during a review meeting on 1/21/15 at 2:00 p.m.

The Drug Information Handbook for Nursing 13th Edition on pages 912 through 914 describes oxycodone and an opioid analgesic used for the management of moderate to severe pain. This

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reference states, "The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drug classes which have a heightened risk of causing significant patient harm when used in error." This reference documents nursing actions to include "Monitor for effectiveness of pain relief...May cause physical and/or psychological dependence..." (1)

(1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.

3. Facility staff failed to follow physician orders for reporting blood sugars greater than 400, obtaining weights and administering medications to Resident #12.

Resident #12 was admitted to the facility on 02/12/2013 with diagnoses including, but not limited to: Dementia, Schizophrenia, Diabetes, Hypertension, Glaucoma and Insomnia.

The most recent MDS (minimum data sheet) was a quarterly assessment with an ARD (assessment reference date) of 12/05/2014. Resident #12 was assessed as moderately impaired in her cognitive skills with a total cognitive score of 11 out of 15.

On 01/21/2015 at approximately 9:00 a.m., Resident #12's medical record was reviewed. Several physician orders were reviewed and included orders that were not followed by facility staff. The first order with a start date of 08/21/2014 stated, "...Blood glucose via fingerstick, notify MD (physician) if results less than 60 or greater than 400..." Subsequent review of the MAR (medication administration

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sheet) for the months of 9/2014, 10/2014, 11/2014, 12/2014 and 01/2015 revealed the following blood sugar results greater than 400: 09/11/2014 - 440; 10/02/2014 - 441; 10/06/2014 - 465; 10/09/2014 - 404; 10/17/2014 - 419; 10/21/2014 - 450; 11/13/2014 - 510; 11/17/2014 - 442; 11/21/2014 - 404; 12/02/2014 - 415; 12/15/2014 - 441; 12/18/2014 - 448; 12/23/2014 - 427; 01/01/2015 - 448; 01/02/2015 - 449. No documentation could be located in the clinical record that the physician had been notified on any of the above listed dates of Resident #12's blood sugars greater than 400.

The Administrator and DON (director of nursing) were notified of the above information during a meeting with the survey team on 01/21/2015 at approximately 2:00 p.m.

On the morning of 01/22/2015 at approximately 7:30 a.m., this surveyor was approached by LPN #4 (licensed practical nurse) regarding Resident #12's increased blood sugar levels. LPN #4 stated, "(Name) physician is aware of this resident's increased blood sugars and increased HgBA1C level. He has written about them in his progress notes." This surveyor and LPN #4 reviewed the physician order that stated, "Notify MD if BS (blood sugar) greater than 400." If he isn't notified then the order is not being followed. LPN #4 agreed with this statement. LPN #4 stated, "So, we need to individualize blood sugar parameters for each resident? Our company's sliding scale says to call MD if BS greater than 400. So, I guess we need to change the prn (as needed) sliding scale parameters to match the others, so we don't have conflicting orders."

The next physician order dated 11/06/2014

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stated, "Daily weights x (times) 7 (seven) days. Documentation in the clinical record included weights for the following dates: 11/07/14, 11/08/14, 11/09/14, 11/10/14, 11/12/14, 11/13/14. Resident #12's weight was not obtained on 11/11/14.

An order dated 11/26/2014 stated, "Weekly weights." Weight results in the clinical record included the following dates: 11/24/14, 12/01/14. No further weights were documented. Weekly weights were missed the week of 12/08/14, 12/15/14, 12/22/14, 12/29/14 and 01/05/15. An order was written on 01/07/2015 that stated, "Monthly weight."

The Administrator and DON were notified of the above weight findings during a meeting with the survey team on 01/21/2015 at approximately 2:00 p.m.

On 01/22/2015 at approximately 12:15 p.m., the DON stated, "(Name) put the order in. Restorative didn't get the order to weigh this resident weekly. The weights were not obtained."

The last physician order was written on 01/14/2015 and stated, "Building wide given (sic) insulins and critical medications. Hold all other meds. due to system being down."

During a meeting with the Administrator and DON on 01/21/2015 at approximately 2:00 p.m., including the survey team, the DON was asked what medications were considered critical meds. The DON stated, "Cardiac Meds and Insulins." At approximately 2:20 p.m., RN #3 (registered nurse) joined the meeting. RN #3 was asked what the order for critical meds included. RN #3

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F 309	Continued From page 33 stated, "Critical meds included meds for anti-seizure, cardiac, hypertension and insulin." Review of the MAR for 01/14/2015 for Resident #12 included documentation that this resident did not receive her Propranolol HCl 20mg (milligrams) po (orally) at 1700 (5:00 p.m.) or her Novolog 6u (six units) SQ (subcutaneously) with meals at 1630 (4:30 p.m.). There was no documentation in the clinical record why these medications were missed. This surveyor attempted to contact the nurse that had documented these missed medications via phone, on 01/21/15 at 1:22 p.m., 01/21/15 at 3:00 p.m. and 01/22/15 at 10:45 a.m. without success. Neither the Administrator or DON could say why these medications hadn't been given. No further information was received by the survey team prior to the exit conference on 01/22/2015.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	F329 Non-pharmacological interventions for insomnia were discussed with Resident #7 on 2/2/15 by the Registered Nurse Assessment Coordinator (RNAC) and reflected in his plan of care. Current Residents with prescribed hypnotic medication were interviewed for non-pharmacological interventions related to insomnia on 2/2/15 by the RNAC, with care plan updates made.	

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as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure one of 24 residents in the survey sample was free from unnecessary medications. Resident #7 was administered the hypnotic medication Ambien for 18 out of 20 days in January 2015 without any prior attempts at non-pharmacological interventions to assist the resident to sleep.

The findings include:

Resident #7 was admitted to the facility on 1/7/13 with diagnoses that included below knee amputation, chronic obstructive pulmonary disease, insomnia, depressive disorder, traumatic brain injury, anxiety, coronary artery disease, congestive heart failure, diabetes, anemia, hypertension, episodic mood disorder and psychosis. The minimum data set (MDS) dated 11/14/14 assessed Resident #7 as cognitively intact and having trouble falling or staying asleep 7 to 11 out of 14 days.

Resident #7's clinical record was reviewed on 1/21/15. The record documented a physician's order dated 9/4/14 for the hypnotic medication

Licensed Nurses to be re-educated by the Director of Clinical Education/designee on or before 2/6/15 as to the requirement for current residents receiving a hypnotic to have attempts at non-pharmacological interventions prior to administration of hypnotics. An order for attempts at non-pharmacological intervention was obtained for each resident receiving a prescribed hypnotic and entered 1-2 hours prior to the administration time of the hypnotic into the electronic medication system.

The Social Worker will run a report of all hypnotics monthly and audit to ensure that care plans are current related to preferred non-pharmacological interventions and review the medical records to ensure that attempts are being made to offer such. Her findings will be submitted to QAPI monthly for three months to ensure compliance with the plan or for additional recommendations if needed.

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Ambien (zolpidem tartrate) 5 mg (milligrams) to be administered as needed for insomnia at bedtime. The resident's medication administration record (MAR) from 1/1/15 through 1/20/15 documented the resident was administered Ambien at bedtime on 18 out of 20 days.

Nursing notes and medication administration notes documented no attempts at any non-pharmacological interventions prior to the administration of Ambien. On eleven days during January 2015 notes documented the resident requested the medication. Other days of administration listed the Ambien was administered as needed for insomnia. The resident's current care plan (print date 1/21/15) included no problems, goals and/or interventions regarding insomnia.

On 1/21/15 at 12:50 p.m. the licensed practical nurse (LPN #2) that routinely administered evening medications to Resident #7 was interviewed about the Ambien. LPN #2 stated on most evenings the resident stated he could not sleep and requested the Ambien. LPN #2 stated, "He (Resident #7) says he can't sleep without it." LPN #2 stated she did not attempt or know of any non-pharmacological to try with Resident #7 to promote sleep. LPN #2 stated Resident #7 frequently got agitated if you did not promptly give him his medication. LPN #2 stated she routinely gave Resident #7 as soon as he requested to prevent him from becoming agitated.

On 1/21/15 at 1:05 p.m. the registered nurse MDS coordinator (RN #1) was interviewed about a care plan for Resident #7's insomnia and of any non-pharmacological interventions to promote

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GOLDEN LIVINGCENTER-ALLEGHANY	1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 36 sleep. RN #1 stated the care plan listed the resident used a hypnotic but did not provide goals and/or interventions concerning his sleep problems. RN #1 stated, "We didn't list insomnia as a problem. I don't see that. We don't have interventions specifically for insomnia." These findings were reviewed with the administrator and director of nursing during a review meeting on 1/21/15 at 2:00 p.m. The Drug Information Handbook for Nursing 13th Edition on page 1264 describes Ambien (zolpidem tartrate) as a hypnotic medication used for the short-term treatment of insomnia. Warnings listed include, "Should be used only after evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve after 7-10 days may indicate psychiatric or medical illness. Hypnotic/sedatives have been associated with abnormal thinking and behavior changes including decreased inhibition, aggression, bizarre behavior, agitation, hallucinations, and depersonalization..." (1) (1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 37	F 371	F371 The snack was removed from the c wing pharmacy refrigerator on 1/21/15. All pharmacy refrigerators were checked on 1/21/15 for improperly stored snacks with no additional issues identified. Licensed nurses to be re-educated by the Director of Clinical Education/designee on or before 2/6/15 as to the policy not to store any snacks in the pharmacy refrigerators. Dining services staff to be re-educated on or before 2/6/15 by the Director of Dining Services as to the proper distribution and storage of snacks. A check list has been added to the temperature log sheet on each pharmacy refrigerator for documenting that the refrigerator has been checked daily to ensure that no snacks have been improperly stored. Refrigerator logs will be collected monthly by the unit managers and forwarded to the QAPI committee for review to ensure compliance with the plan of correction and additional recommendations if needed. Compliance date: 2/11/15	

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility staff failed to store food in a sanitary manner in one of 3 medication rooms: C wing. The medication refrigerator contained unlabeled food.

Findings include:

On 1/21/15 at approximately 1:50 p.m. an inspection of the C wing medication room refrigerator was conducted with LPN (licensed practical nurse) # 6. During the inspection, a package of food was observed in the refrigerator. This surveyor asked LPN # 6 about the food. LPN # 6 stated "I didn't even know that was in there! Maybe it belongs to (name of resident)." This surveyor asked LPN # 6 if the medication refrigerator was where resident food was kept. LPN # 6 stated "No, there should not be any food in this refrigerator."

The administrator and DON (director of nursing) were informed of the above observations during a meeting with facility staff 1/21/15 beginning at 2:15 p.m. A copy of the facility policy regarding resident food items was also requested at that time. The DON stated "I'm not sure about a policy but the resident's have a refrigerator for their food. Food should not be kept in the medication refrigerator."

No further information was provided prior to the exit conference.

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure medications were available for administration for one of 24 residents, Resident #9. Resident #9 did not receive her physician ordered Prolixin on 01/14/2015. The medication, prescribed for treatment of Bi-polar disorder, was ordered to be given in the morning and at bedtime. Neither dose was given as the medication was not in the facility. Findings were:	F 425	F425 Resident #9 received her prescription of Prolixin with the pharmacy delivery on the night of 1/14/15. Current medication supplies were checked by nursing administration on 1/26/15 to ensure medications were available with corrective action taken as needed. Licensed nurses to be re-educated by the Director of Clinical Education/designee on or before 2/6/15 as to the process to order/reorder medication from the pharmacy and steps to take if medication not received timely. Any identified issues will be noted on the 24 hours report for the Unit Manager to provide assistance with any identified issues that cannot be resolved by the Charge Nurse with the pharmacy. Unit Managers will conduct weekly cart audits to ensure that processes are being followed and that all medications are available for administration. The Unit Managers will report findings of their cart audits to the DNS during the weekly clinical meeting. The DNS will trend issues and review with the QAPI committee monthly time three months to ensure compliance with this plan of correction and for additional recommendations if required. Date of Compliance: 2/11/15	

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Resident #9 was originally admitted to the facility on 06/11/2014. Her admitting diagnoses included, but were not limited to: Bipolar disorder, cerebral palsy, pulmonary heart disease, and primary pulmonary hypertension.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 01/14/2015. Resident #9 was assessed as having a cognitive summary score of "15", indicating she was cognitively intact.

The clinical record was reviewed on 01/21/2014 beginning at approximately 9:00 a.m. The physician order sheet contained an order for Fluphenazine HCL (Prolixin) 10 mg to be given in the morning and at bedtime. The MAR (medication administration record) was reviewed. On 01/14/2015 the number "3" and initials were listed in the space indicating whether or not the medication was given. The chart codes listed on the MAR for the number "3" were: "3 (equal sign) Hold/See Nurse (sic) Notes".

The nurse's note section was then reviewed. A note written on 01/14/2015 at 0507 (5:07 a.m.) read: Fluphenazine HCL 10 mg PO (by mouth) not given, did not arrive from pharmacy." Also noted was a note dated 01/15/2015 0008 "12:08 a.m.) that read: "Medications on hold by MD due to system being down."

During an end of the day meeting with the DON (director of nursing) and the administrator the above information was discussed. The DON stated that they would find out why the medications were not available and let this surveyor know the following day.

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On 01/22/2015 at approximately 11:00 a.m., LPN (licensed practical nurse) #4 came to the conference room she stated, "The Prolixin for (name of Resident #9) was ordered on 01/13/2015. It usually arrives at night and should have been here on the night shift. For some reason it did not arrive until the night shift of 01/14/2015 so it was not here for her to receive at either scheduled time...it had nothing to do with the system being down."

No further information was obtained prior to the exit conference on 01/22/2015.

F 441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS — F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

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F 441	Continued From page 41 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to follow infection control practices during wound care for one of 24 residents, Resident #4. LPN (licensed practical nurse) #4 did not thoroughly wash her hands during a dressing change, was observed to turn off the faucet with her bare hands and left a tube of "Multidex" uncapped and lying against a red bag containing contaminated items from the dressing change. Findings were: Resident #4 was originally admitted to the facility on 02/27/2012. Her diagnoses included but were not limited to: Depressive disorder, Recent Left AKA (above knee amputation), hypothyroidism and anxiety.	F 441	F441 LPN #5 is on a leave of absence. She will be re-educated and checked off on dressing changes prior to returning to direct care upon her return from her loa. All Residents with current dressing change orders have the potential to be affected. All staff to be re-educated by the Director of Clinical Education/designee on or before 2/6/15 on proper techniques for hand washing. Licensed Nurses to be re-educated by the Director of Clinical Education/designee on or before 2/6/15 regarding proper dressing change infection control practices with associated skills check. Unit Managers will complete a minimum of 2 dressing change observations per week with re-education provided if needed and documentation of the observation submitted to the DNS. The DNS/designee will trend any issues noted from the Unit Manager observations and submit monthly to QAPI times 3 months for review and additional recommendations if required. Compliance date: 2/11/15	

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F 441	Continued From page 42	F 441		

The most recent MDS (minimum data set) was significant change assessment with an ARD (assessment reference date) of 12/01/2014. Resident #4 was assessed as having a cognitive summary score of "04", indicating severe impairment in her cognitive status.

On 01/22/2015 at approximately 10:00 a.m., a dressing change observation was conducted with LPN #5 who was assisted by RN (registered nurse) #4. LPN #5 stated that Resident #4 had been medicated for pain prior to the procedure. Resident #4 was turned to her left side. LPN #5 gathered her supplies for the dressing change and pulled Resident #4's brief out from under her. After getting the resident into position LPN #5 washed her hands. She was observed to wash her hands for approximately 7 seconds, she dried her hands and placed the soiled paper towel in a red biohazard bag on the resident's bed. She then turned the water off with her bare hand. LPN #5 continued with the dressing change. Resident #4 had two small areas, one on each side of her buttocks, located in the gluteal fold. LPN #5 treated the wound in the left gluteal fold first. The area was cleaned with wound cleanser and wiped with a nonsterile 4X4 gauze. LPN #5 removed her gloves and again washed her hands for approximately 5-7 seconds. She returned to the bedside and removed the cap from a tube of Multidex. She placed the cap on a clean dry towel on the bed. She used a nonsterile q-tip to apply the Multidex. LPN #5 stated, "This stuff is like honey, it will run, you have to move quickly when you use it."After applying the Multidex, LPN #5 removed her nonsterile gloves and again washed her hands for approximately 5 seconds. She returned to the bedside and picked up one of the dirty gloves she had placed in the red

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F 441	Continued From page 43	F 441		

biohazard bag. She stated, "I grabbed the wrong thing, I need to start all over." She returned to the sink to wash her hands. When she returned to the bedside she realized that she had placed the used q-tip in the bag with her clean supplies. She stated, "I put that in the wrong bag, I need to start over again." She left the bedside and retrieved a box of nonsterile gloves. She returned to the sink and washed her hands. She dried her hands and used her bare hand to turn the water off. She then covered the wound with a tegaderm pad. She then repeated the same treatment to the right gluteal fold. During the dressing change to both gluteal folds the tube of Multidex was observed to be uncapped and lying in the white towel at the foot of the bed. During the dressing change the red biohazard bag containing the soiled supplies was observed to be in contact with the opened end of the tube.

After the dressing change was complete, LPN #5 was interviewed. LPN #5 was asked how long she usually washed her hands during a procedure. She stated, "I didn't wash them very long because you have to move so quickly with the Multidex..." LPN #5 was asked how long she was suppose to wash her hands per facility policy. She stated, "One minute." LPN #5 was asked about the lid being left off of the Multidex during the procedure. She stated, "I usually do that because you have to move so fast when you are using it...it is like honey and it will run down off of the wound." It was pointed out to LPN #5 the the opened top of the Multidex had come in contact with the red biohazard bag. She stated, "Okay."

A copy of the facility policy on handwashing during dressing changes was requested.

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F 441	Continued From page 44 According to the policy titled, "Handwashing/Hand Hygiene": "Washing Hands Vigorously lather hands with soap and rub them together creating friction to all surfaces for a minimum of 15 seconds (or longer) under a moderate stream of running water...dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel." During the dressing change observation LPN #5 did not wash her hands greater than 7 seconds at any time. She also did not follow facility policy when turning off the water. Each time she either used the paper towel she used to dry her hands or her bare hands to turn the water off. The DON (director of nursing) and the administrator were notified of the above information during a meeting on 01/22/2015 at approximately 11:30 a.m. No further information was obtained prior to the exit conference on 01/.22/2015.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514	F514 Resident #20 was deceased prior to the survey. A new inventory sheet was prepared by the social worker for Resident #15 on 2/2/15 with appropriate signatures. The Executive Director printed paper MARs for additional backup on 1/14/15. The corporate IT department reconfigured the facility electronic backup system on 1/21/15. Open charts were audited by social services and medical records on 11/26/15 to ensure they contained only records for the associated resident. This audit occurred again on 1/31/15 along with auditing the completeness of inventory sheets.	

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F 514	Continued From page 45 and progress notes.	F 514		

This REQUIREMENT is not met as evidenced by:
Based on review of a Facility Reported Incident, clinical record review, facility document review, staff interview, and observations, the facility staff failed to maintain complete and accurate clinical records for two of 24 residents in the survey sample (Residents # 15 and 20), and failed to maintain complete, accurate and accessible electronic medical records on two of three nursing units.

1. The staff filed a yellow Do Not Resuscitate form belonging to another resident in the clinical record of Resident # 20, which prevented the initiation of cardiopulmonary resuscitation during a cardiac event.

2. Resident #15 did not have a completed inventory of personal possessions.

3. Facility staff failed to maintain a complete, accurate and accessible electronic, medical record on two of three units, Unit A and Unit B, on 01/14/2015 during a system wide outage.

The findings include:

1. The staff filed a yellow Do Not Resuscitate form belonging to another resident in the clinical record of Resident # 20, which prevented the initiation of cardiopulmonary resuscitation during a cardiac event.

Resident # 20 in the survey sample, an 88 year-old male, was admitted to the facility on

A new process was initiated on 11/24/14 in which a label with the Resident's name clearly printed in Red Ink was placed at the top of each DNR form to ensure easy validation to minimize risk of misfiling from illegible writing. At that time, staff with access to Medical Records, including hospice nurses were in-serviced on this new process along with re-education on the critical aspect of double checking that documents are being filed into the correct resident jacket. Staff will be re-educated to maintain a back-up system to the electronic medical record and the requirement to sign inventory sheets on or before 2/6/15 by the Director of Clinical Education/designee. Inventory sheets will be brought by the appropriate unit manager to stand-up the morning post admission for review of completeness and corrective action if required. Paper MARs will be printed on admissions and monthly and maintained for nurse access in the event of a system wide failure.

The Executive Director/designee will run a list of new DNR orders during the completion of the monthly operations report. The charts affected will be checked to ensure that the documents for that Resident are in the Resident's

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6/10/11 with diagnoses that included hypertension, cerebral atherosclerosis, history of femoral neck fracture, Alzheimer's Disease, anxiety state, hyperlipidemia, peripheral vascular disease, and osteoporosis. According to a Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/22/14, and Medicare 60-Day MDS with an ARD of 11/10/14, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

Review of the Progress (Nurses) Notes in the resident's closed clinical record revealed the following entries:

11/21/14 - 3:04 a.m. "Resident at 0248 observed by staff during an adl (Activities of Daily Living) round with no signs of life. Notified RN (Registered Nurse) on duty in facility. RN assessed resident. RN observed no vital signs. RN also notified MD and nursing supervisor and family. Family gave facility funeral home preference and the funeral (home) was contacted by RN."

11/21/14 - 3:11 a.m. "At approx (approximately) 0245 c-wing nurse notified this writer of possible death this nurse assessed resident for signs of life resident presented with no respirations or pulse this writer pronounced death at 0248 this writer notified nursing supervisor, M.D., and next of kin family gave funeral home preference funeral home notified.(sic)"

According to the Death Certificate, the immediate cause of death for Resident # 20 was myocardial infarction.

jacket and have been labeled as per the new process. The ED will report findings to both the Area VP and QAPI via the OPS report for additional follow-up. Nursing Administration will continue their end of month chart audits with greater focus on ensuring that documents are housed in the correct Resident's file jacket. Any identified concerns will be corrected immediately and reported to the DNS for trending and follow-up to the QAPI committee. Medical Records will randomly audit 5 inventory sheets per month to ensure completeness and report any issues to the QAPI committee for additional recommendations. All electronic medical record system failures will be reported by the DNS to the QAPI committee at their next meeting for review of the back-up system and ensured compliance with this plan.

Date of compliance: 2/11/15

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Resident # 20's clinical record included a "Resuscitation Orders" form, dated 6/13/11 and signed by the attending physician, that noted the following:

"The resident or the resident's decision maker is aware of the medical condition of the resident. After fully discussing and considering the risks/benefits and alternatives to the initiation of CPR in a cardiac or respiratory arrest, the resident or the resident's representative had made the following decision: In the event of a cardiac and/or respiratory arrest, initiate CPR."

On 11/24/2014, the facility submitted a Facility Reported Incident (VA00030682) that noted the following, "Resident pronounced dead at 2:48 am by the RN charge nurse. Resident noted during the Director of Nursing's follow-up chart review to have a current order for full code."

The facility's investigation report of the event noted the following. "LPN (name) checked (name of Resident # 20) chart and found a yellow DNR (Do Not Resuscitate) form and determined (name of Resident # 20) to be a DNR." Based on the finding of the DNR form by the LPN (identified by the survey team as LPN # 7), resuscitation efforts were not initiated and the Resident # 20 was pronounced as deceased.

The investigation report further noted that it was "...later discovered during chart review that the yellow DNR form in (name of Resident # 20) was not his, but belonged to another resident (Resident # 24)."

On 1/22/15 at 1:30 p.m., during an overview of

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the facility's Quality Assurance Program, the Administrator said that LPN # 7 looked at Resident # 20's chart, saw the DNR form and incorrectly assumed it was for Resident # 20. According to the Administrator, the signatures of Residents # 20 and 24 looked to be similar, so when LPN # 7 looked at the signature, she thought the DNR form was for Resident # 20. The Administrator went on to say that it was during the chart review conducted by the Director of Nursing after the resident's death that it was discovered the DNR form for Resident # 24 was incorrectly filed in Resident # 20's clinical record.

2. Resident #15 did not have a completed inventory of personal possessions.

Resident #15 was admitted to the facility on 7/23/14 with diagnoses that included: Schizophrenia, dementia with behaviors, depression, deaf, reflux, and CVA.

The most recent MDS (minimum data set) was a quarterly with an assessment reference date of 1/6/15, Resident #15 was assessed as being moderately cognitively intact with a score 9 of 15.

Resident #15's medical record was reviewed on 1/22/15 and revealed an admission "inventory of personal possessions" form without a date or signatures and an updated inventory list without signatures.

On 1/22/15 at 9:00 a.m. the social worker was questioned regarding the inventory form. The social worker verbalized that upon admission all items are to be descriptively written on the inventory list and dated, signed by the admission nurse or certified nursing assistant. If family is with the resident during admission,the family are

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suppose to sign also, unless the resident can sign for themselves.

The social worker was shown both of Resident #15's inventory list and verbalized that the forms should have been signed and dated.

On 1/22/15 at 11:15 a.m. the above finding was brought to the attention of the director of nursing and administrator. The administrator agreed that Resident #15 inventory list should have been completed with date and signature.

No other information was present prior to exit conference on 1/22/15.

3. Facility staff failed to maintain a complete, accurate and accessible electronic, medical record on two of three units, Unit A and Unit B, on 01/14/2015 during a system wide outage.

During the survey conducted 01/21/15 - 01/22/15 an order written 01/14/2015, filed in the paper clinical records was noted that stated, "Building wide given (sic) insulins and critical medications. Hold all other meds. due to system being down."

During a meeting with the Administrator, DON (director of nursing) and the survey team on 01/21/2015 at approximately 2:00 p.m., facility administration was interviewed regarding the above order and system outage. The Administrator stated, "PCC system wide was down. The software was down company wide." Administration was asked how resident medications were given during this outage since the facility medication administration system is electronic. The Administrator stated, "(Name) RN #3 (registered nurse) is who actually came in and handled the situation." The DON stated, "I was

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out of town during the outage."

RN #3 joined the meeting at approximately 2:20 p.m. RN #3 stated, "(Name) (another nurse) was actually called first. I was at home on hold with IT (information technology) for forever trying to see how long the outage was going to last. In the meantime, (Name) physician was notified of the system outage and he gave the order to give only insulin and critical meds. I finally hung up on IT and came to the facility to show the nurse's how to take orders off the hard charts. The system went down around 7:00 o'clock and I got to the facility around 8:30 - 8:45 p.m. Nurses were on the floor giving meds when I arrived. They were supposed to document in the system what meds were given when it came back up."

At approximately 3:40 p.m., Other #4 entered the conference room with two packets in hand. Other #4 stated, "These are downtime packets that were formed after the derecho in July 2013." The packets included a "clinical computer systems downtime package" and "care tracker documentation" (for ADL's - activities of daily living) when kiosk goes down. She stated, "I don't know why they didn't use these when the system went down. They have all of the old paper forms we used to use. Staff were inserviced on these when they were formed." A copy of the staff inservice sheets was requested by the survey team, but were never received.

On 01/22/2015 at approximately 7:20 a.m., this surveyor was approached by the Administrator and was shown the "Disaster Computer" in its location. The Administrator stated, "This computer automatically downloads all medical records every two hours. If the system goes

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down you can print MAR's/TAR's (medication administration records/treatment administration records) from this computer. However, on the night in question we were not able to print from this computer. I assumed it was a software issue, but have since found out this computer has to be directly connected to the Lexmark printer in order to print. (Name), head of the IT dept., is going to send me a cheat sheet to use in the future." The Administrator then handed me a copy of a disaster drill that had been conducted on December 23, 2014, on how to use the disaster computer. The Administrator then stated, "I just wanted you to know the company does have drills to make sure the system is working properly. Any time this computer goes off I get an alert sent to my phone. I call the building and have someone go turn the computer back on, like during the ten second delay when the generator comes on."

At approximately 11:45 a.m. on 01/22/2015 the survey team met with the Administrator and DON. The Administrator shared the above information again. She stated, "I thought the computer wouldn't print because of a software issue, but (name) IT told me the software doesn't have any effect on the disaster computer. The problem was, the printer was not configured correctly and that is why we were not able to print the MAR's/TAR's when the system went down."

The Administrator was asked who had conducted the recovery drill on December 23, 2014. She stated, "(Name) DON, but she was out of town when the system went down." She was then asked where is the disaster recovery guidelines kept in the facility. The Administrator stated, "With the disaster computer, but I again thought it

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F 514	Continued From page 52 wouldn't print because of a software issue, not a printer issue." No further information was received by the survey team prior to the exit conference on 01/22/2015.	F 514		